DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 1 4 (B)

2. STATE: South Carolina

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR Part 447

7. FEDERAL BUDGET IMPACT:
a. FFY 2002 $ 43,415
b. FFY 2003 $ 39,180

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, Pages 1-4, 12, 17-21, 29-34 and 37-41

Attachment 4.19-B Page 1a.1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, Pages 1-4, 12, 17-21, 29-34 and 37-40.

10. SUBJECT OF AMENDMENT:
Changes in inpatient and outpatient hospital payment methodologies, use of updated data in the DSH program, no change in Psychiatric Residential Treatment Facility rates.

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
William A. Prince

13. TYPED NAME:
William A. Prince

14. TITLE:
Director

15. DATE SUBMITTED:
December 12, 2001

16. RETURN TO:
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
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18. DATE APPROVED:
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PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
October 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Eugene A. Grasser

22. TITLE: **Associate Regional Administrator**
Division of Medicaid and State Operations

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF SOUTH CAROLINA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
INPATIENT HOSPITAL AND PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY CARE

I. General Provisions

A. Purpose

This plan establishes a prospective payment reimbursement system for inpatient hospital services and inpatient psychiatric residential treatment services in accordance with the Code of Federal Regulations. It describes principles to be followed by Title XIX inpatient hospital and psychiatric residential treatment providers and presents the necessary procedures for setting rates, making adjustments, auditing cost reports and managing the hospital disproportionate share program.

B. Objectives

Pursuant to the requirements of the Omnibus Budget Reconciliation Act (OBRA) of 1981 that provider reimbursements be reasonable and adequate to assure an efficient and economically operated facility, the prospective rate plan herein described will apply.

Effective October 1, 1997, the Balanced Budget Act (BBA) of 1997 repeals the OBRA 1981 requirement stated above. In its place, the BBA of 1997 provides for a public process for determination of hospital payment rates. This public process will take place for all changes in payment for inpatient hospital and psychiatric residential treatment facility services and disproportionate share.

C. Overview of Reimbursement Principles

1. The South Carolina Medicaid Program will reimburse qualified providers for inpatient institutional services using one or more of the following methods.

   a. Effective January 1, 1986, reimbursement will be based on prospective payment rates developed for each facility as determined in accordance with this plan.

   b. Effective August 1, 2001, South Carolina non-state owned public facilities will be eligible to receive lump sum payments from a

pool of funds (the 150% Upper Payment Limit (UPL) Pool). Payments to each facility will be made in accordance with the UPL regulations 42 CFR 447.271 and 447.272.

c. Effective for services provided on or after October 1, 2001, the following South Carolina small rural public hospitals will be eligible to receive inpatient and outpatient cost settlements in accordance with the methodology outlined on page 32 of 4.19-A and page 1a of 4.19-B.

Abbeville County Memorial	Edgefield County Hospital
Allendale County Hospital	Fairfield Memorial Hospital
Bamberg County Memorial	Kershaw County Memorial
Barnwell County Hospital	Marion County Medical Center
Chester County Hospital	Williamsburg Regional Hospital
Clarendon Memorial Hospital	

2. Medicaid reimbursement to a hospital shall be payment in full. Hospitals may not separately bill the patient or the Medicaid program for medical services rendered during an inpatient stay, except as provided in Section III of this plan. Hospitals may submit a claim for payment only upon final discharge of the patient, with the exception of long-term care psychiatric hospital claims and psychiatric residential treatment facility claims.

3. All inpatient services associated with admissions occurring on or after January 1, 1987, furnished by hospitals, are subject to the Hybrid prospective payment system. Special prospective payment system provisions are included for services provided by freestanding long-term care psychiatric hospitals.

4. Payment for all hospitals except those identified in 3 above will be made based on a Hybrid system which compensates hospitals either an amount per discharge (per case) for a diagnosis related group or a prospective per diem rate. DRG categories that are frequent, relatively homogeneous and considered by clinical experts not to be of a highly specialized nature will be paid an amount per discharge for each DRG category. DRG categories that are infrequent, highly variant and/or are considered by clinical experts to be of a highly specialized nature will be paid a hospital-specific per diem rate appropriate for the type of service rendered.

5. For discharges paid by the per case method under the Hybrid System, South Carolina specific relative weights and rates will be utilized. The DRG classification system to be used will be the classification system currently used by the Medicare program. The relative weights will be established based on a comparison of charges for each DRG category to charges for all categories. South Carolina's historical Medicaid claims database will be used to establish the DRG relative weights.

6. For discharges paid by the per diem method, an appropriate hospital-specific per diem rate will be established for the type of service.

The per diem rate will distinguish routine, special care, and neonatal intensive care days and will further distinguish these into surgery and non-surgery cases. Facilities will receive the appropriate per diem rate times the number of days of stay, subject to the limits defined in this plan.

7. An outlier set-aside adjustment (to cover outlier payments described in 10 of this section) will be made to the per discharge rates.

8. Payment for services provided in freestanding long-term care psychiatric facilities shall be based on the statewide average per diem for psychiatric long-term care. The base per diem rate will be the statewide total costs of these psychiatric services divided by total psychiatric days.

9. The prospective payments determined under both payment methods, the Hybrid prospective payment system for general acute care hospitals, distinct part units and short term care psychiatric hospitals and the per diem method for psychiatric long-term care facilities will be adjusted to recognize facility specific costs associated with direct and indirect medical education, capital and ancillary services as appropriate. Capital and direct medical education will be reimbursed prospectively on an interim basis, and retrospectively settled at a future date. Disproportionate share hospitals will not be eligible for cost settlements in accordance with the upper payment limit requirements of the OBRA 1993. Effective October 1, 1999, South Carolina Department of Mental Health hospitals will be reimbursed 100% of their allowable Medicaid inpatient cost through a retrospective cost settlement process.

10. Special payment provisions, as provided in Section VI A of this plan, will be available under the Hybrid prospective payment system for discharges paid by DRG which are atypical in terms of patient length of stay or costs of services provided during the stay. These cases will be referred to as outliers. Special payment policies, as specified in Section VI C and D of this plan, will also be made for cases involving a transfer of a patient from one hospital to another, or a readmission of a patient following an earlier discharge. These provisions are not applicable to long-term psychiatric and RTF claims.

11. Reduced payment, as specified in Section VI B of this plan, will be made for cases paid on a per diem basis having stays exceeding two hundred percent of the hospital specific average length of stay.

12. A rate reconsideration process will be available to hospitals which have higher costs as a result of conditions described in IX B of this plan.

13. Disproportionate share payments will be paid to qualifying hospitals in accordance with the requirements specified in Section VII of this plan.

14. Payment for services provided in psychiatric residential treatment facilities shall be an all-inclusive per diem rate. Section II paragraph 29 of this plan defines the costs covered by the all-

inclusive rate. Each facility's per diem rate will be calculated using base year data trended forward. Section V B describes the rate calculation.

15. Effective October 1, 1998, reimbursement for statewide pediatric telephone triage services will be available for the designated South Carolina Children's Hospitals. Payment will be based on the Medicaid portion of allowable service cost.

16. Effective October 1, 1999, a small hospital access payment will be paid to qualifying hospitals that provide access to care for Medicaid clients.

17. Effective October 1, 1999, a high volume Medicaid adjuster payment will be paid to hospitals that serve a significantly high volume of Medicaid patients.

18. Effective October 1, 2000, hospitals participating in the SC Universal Newborn Hearing Screening, Detection, and Early Intervention Program will be reimbursed for Medicaid newborn hearing screenings. Effective July 1, 2001, all hospitals will be eligible for this reimbursement.

19. Effective August 1, 2001, South Carolina non-state owned public hospitals will be eligible for a lump sum payment from a newly created Upper Payment Limit pool. Payment will be made as described in Section VIII of this plan.

20. Effective for admissions on or after October 1, 2001, hospitals will be reimbursed for Norplant and Depo-Provera.

III. Services Included in the Prospective Payment Rate

1. Acute Care Hospitals

The prospective payment rate will include all services provided in an acute inpatient setting except:

a. Professional component, including physician and CRNA services and any other professional fees excluded under Part A Medicare.

b. Ambulance, including neonatal intensive care transport.

2. Psychiatric Residential Treatment Facilities

The per diem reimbursement rate will be the ''all-inclusive" rate as defined in Section II, item 30 of this plan.

fiscal year cost will be adjusted to reflect dollars as of a single point in time (12/31/90). For example, a facility with a 6/30 fiscal year end will have an additional inflation factor applied to its costs. This inflation factor will be calculated by dividing the number of days between 6/30 and 12/31 (184) by 365. The resulting percent will be multiplied by the applicable TEFRA Non-PPS factor. This factor will be calculated by adding 1.00 to the sum of the values derived from multiplying 5.2% times 9/12 (9 months of FY 1990) and multiplying 4.4% times 3/12 (3 months of FY 1991).

2. A factor will be calculated to inflate costs from July 1, 1990 (midpoint of December 31, 1990 fiscal year) to January 1, 1994 (midpoint of June 30, 1994 fiscal year). Adding 1.00 to a through e below and then multiplying these numbers together calculate this factor.

   a. 3/12 x .052
      (three months of the FY 1990 rate of increase)

   b. 12/12 x .044
      (twelve months of the FY 1991 rate of increase)

   c. 12/12 x .047
      (twelve months of the FY 1992 rate of increase)

   d. 12/12 x .047
      (twelve months of the FY 1993 rate of increase)

   e. 3/12 x .049
      (three months of the FY 1994 rate of increase)

   This factor 1.173522 is applied to Medicaid cost in the rate calculation.

3. In subsequent rate years, the DHHS will inflate the PPS rates using the lesser of the DRI Hospital Market Basket, the TEFRA Non-PPS rate of increase or an inflation factor set by the DHHS. Inflation will be applied using the midpoint-to-midpoint inflation policy. In addition, for future rate rebasing, previous estimates of inflation for prior years may be corrected to new estimates or to the actual amount if available. An adjustment will be necessary when a previously used estimate is higher than the actual TEFRA Non-PPS rate of increase.

   Effective October 1, 1999, the DHHS increased the PPS base rates (excluding add-on components) by 15% in order to address the reduction in DSH funding effective in federal fiscal year 2000.

   Effective for admissions on or after October 1, 2001, the PPS base rates (excluding add-on components) will be increased by 7%.

   The DHHS will inflate the hospital PPS rates ensuring compliance with the Medicare upper limit test. The PPS base rates (excluding add-on components) shall be updated as follows:

FY 1994-1995	0.0%

FY 1995-1996	6.0%
FY 1996-1997	0.0%
FY 1997-1998	4.0%
FY 1998-1999	0.0%
FY 1999-2000	15.0%
FY 2000-2001	1.0%
FY 2001-2002	7.0%

E. Medicaid Inpatient Discharges and Days

In the case of per discharge (also called per case) reimbursement, the number of Medicaid discharges for patients including nursery is required. In the case of per diem reimbursement, the number of Medicaid days is required. The sources for these data are described below.

1. The number of discharges for the hospital 1990 fiscal year will be the sum of the number reported on Worksheet S-3 (HCFA-2552) as Medicaid discharges. These discharges are multiplied by the proportion of per case discharges to total 1990 claim discharges to get per case discharges.

2. The reported Medicaid inpatient days from Worksheet S-3 are multiplied by the proportion of per diem category days to total 1990 claim days to get per diem days.

3. The number of days for freestanding long-term care psychiatric hospitals will be the number on Worksheet S-3.

F. DRG Relative Weights

Relative weights used for calculating reimbursement for cases paid by discharge will be derived from South Carolina Medicaid hospital claim data. All claims, including those subsequently paid by per diem are included in the relative weight computation. The methodology used for computing relative weights utilizes claim charge data and is described below.

1. Hospital claims with admission dates on or after January 1, 1989 and paid as of April 30, 1993 are included in the computation and prepared as follows:

   a. Claims are edited to merge interim bills for the same discharge.

   b. Claims with lengths of stay greater than 200 days, patient ages less than zero and paid amounts less than or equal to zero are deleted.

   c. Claims containing information clinically inconsistent through application of the Medicare code editor software are deleted.

   d. DRGs are assigned to the claims using the HCFA Grouper versions 6 and 10.

e. Claims with allowed charges greater than $1,000,000 and less than zero, lengths of stay greater than 1000 days and less than zero lengths of stay which could not be reconciled to the sum of the days associated with the line item detail, out-of-state non-border hospitals and other excluded providers are deleted.

f. Charges for varying years are adjusted to represent a common year through application of inflation indices described in Part D of this section.

g. Transfer claims, with the exception of DRGs 385 and 456, are deleted.

h. Readmissions within 1 day are discarded.

2. Relative weights are computed by calculation of the average Medicaid charge for each DRG category divided by the average charge for all DRGs.

3. Relative weights assigned to per diem cases are not used.

4. No adjustments are made to the relative weights.

G. Per Diem Relative Weights

A statewide per diem relative weight is computed for each of the six categories described in V A 2 of this plan. These weights are developed in order to adjust the hospital-specific per diem rates to reflect the appropriate level of care. These weights are calculated in a manner similar to the calculation of DRG relative weights as follows.

All FY 1990 claim charges reimbursed under the per diem reimbursement method are separated into the six per diem categories. An average charge for each category is determined, as well as an average charge for all per diem claims. The extremely high and low claims are deleted. The average charge for each category is divided by the average charge for all per diem categories to compute the relative weights. For each hospital the per diem case-mix index will be computed by multiplying the number of cases in each per diem category by the relative weight for that category, summing the result across per diem categories and dividing by the total number of per diem cases during the base year.

H. Medicaid Case-Mix Index

A case-mix index which is a relative measure of a hospital's resource use, will be used to adjust the per discharge and per diem cost amounts to the statewide average case-mix. Two case-mix indices are calculated for each facility under the Hybrid system. One for the cases paid per discharge and one for the cases paid per diem.

1. For each hospital the per discharge case-mix index will be computed by multiplying the number of FY 1990 claims in each per case DRG by the DRG relative weight, summing these amounts and dividing by the

sum of the total per case discharges.

2. For each hospital the per diem case-mix index will be computed by multiplying the number of FY 1990 category days by the applicable category weight across the six categories; summing these amounts and dividing by the sum of the total FY 1990 per diem days across the six categories.

I. Per Diem Reimbursement Categories

Hospital-specific per diem rates shall be calculated for six (6) or more categories where appropriate as described in Section V of this plan. The six categories are: Routine with Surgery, Routine without Surgery, Special Care with Surgery, Special Care without Surgery, Neonatal Intensive Care with Surgery, and Neonatal Intensive Care without Surgery. The calculation of the per diem for each category requires a statewide per diem category relative weight as described in G above. These relative weights will be applied to the per diem cost per day to yield the rate for each per diem category.

J. Outlier Set-Aside Factor

The outlier set-aside factor will be computed by dividing the projected outlier payments by total payments in a full year period. Only claims for cases to be paid by the per discharge method will be included in this analysis. The outlier set-aside factor for the Hybrid PPS effective 10/1/93 will be .08472. The DHHS may adjust future set-asides to reflect more current information.

K. Psychiatric Residential Treatment Facility Costs

Psychiatric residential treatment facility per diem reimbursement rates, effective for dates of service beginning on or after 09/01/99, shall be calculated using each facility's allowable costs in accordance with HCFA Publication 15-1 and the all-inclusive rate definition. Cost will come from each facility's 1997 HCFA 2552(Medicare/Medicaid Cost Report), with exception when applicable (e.g. professional service costs and subsequent period costs).

If applicable, add-ons will be calculated and applied to the RTF rate for services required by the RTF program subsequent to the 1997 cost reporting period. These add-ons will be calculated using future cost report and/or budgeted cost and statistical data.

Each facility's occupancy rate will be calculated. If a facility's occupancy rate is less than the statewide average RTF occupancy rate, the rate will be adjusted to reflect RTF days at the statewide average occupancy level. No occupancy adjustment will be made for state-owned and operated facilities.

The 1997 base year psychiatric RTF costs will be inflated using the HCFA Market Basket Indices. The base year cost will be inflated through 12/31 of the base year and then the midpoint-to-midpoint inflation method will be used to inflate the rates from the base year to the rate

period. If applicable, add-ons will be inflated forward. The midpoint-to-midpoint inflation rates are as follows:

FY 2000	6.37%
FY 2001	11.43%
FY 2002	11.43%

Because audited cost reports are not available for the base year, desk audited cost report data will be used to set an interim rate. This interim rate will be effective until audited data is available. After an audit is performed, the interim rate may be adjusted to reflect audited allowable cost. If the rate is revised, all payments calculated with the interim rate will be adjusted to reflect payment with the final rate. See section X C 4 for retrospective cost settlement requirements.

F. Payment for Swing Bed Days

Acute care facilities will be reimbursed for qualifying skilled and intermediate care Medicaid patients in accordance with the daily rate schedule shown below.

October 1, 1992 - September 30, 1993	$62.67
October 1, 1993 - September 30, 1994	67.22
October 1, 1994 - September 30, 1995	70.36
October 1, 1995 - September 30, 1996	75.84
October 1, 1996 - September 30, 1997	79.01
October 1, 1997 - September 30, 1998	83.38
October 1, 1998 - September 30, 1999	86.69
October 1, 1999 - September 30, 2000	92.64
October 1, 2000 - September 30, 2002	96.85

This rate calculation is described in the Nursing Home State Plan Attachment 4.19 D, page 35, paragraph I. No rate increase is effective for services provided on or after October 1, 2001.

G. Payment for Administrative Days

Acute care facilities will be reimbursed for Medicaid eligible skilled or intermediate patients who no longer require acute care and are waiting for nursing home placement. Administrative days must follow an acute inpatient hospital stay and will be covered in any hospital as long as a nursing home bed is not available. Reimbursement for administrative days is described below.

1. Each administrative day will be paid in accordance with the rate schedule shown below. This daily rate will be considered payment in full. There will be no cost settlement. This rate is a combination of the swing bed rate, as defined above, plus the Alternative Reimbursement Method (ARM) rate for pharmaceutical services.

October 1, 1994 - September 30, 1995	$73.98 (ARM $3.62)
October 1, 1995 - September 30, 1996	79.68 (ARM 3.84)
October 1, 1996 - September 30, 1997	83.23 (ARM 4.22)
October 1, 1997 - September 30, 1998	88.02 (ARM 4.64)
October 1, 1998 - September 30, 1999	91.79 (ARM 5.10)
October 1, 1999 - September 30, 2000	98.21 (ARM 5.57)
October 1, 2000 - September 30, 2002	103.85 (ARM 7.00)

2. A rate of $180.00 per day will be available for administrative day patients who require more intensive technical services (i.e. patients who have extreme medical conditions which require total dependence on a life support system). This rate was determined by cost analysis of:

   a. A small rural S. C. hospital which was targeted to set up a ward to provide services for this level of care and

   b. An out-of-state provider that has established a wing in a

nursing facility to deliver this type of service.

This per diem rate will represent payment in full and will not be cost settled.

H. Payment for One-Day Stay

Reimbursement for one-day stays that group to per discharge DRGs (except deaths, false labor, normal deliveries (DRG 373) and normal newborns (DRG 391)) will be reimbursed a DRG per diem. A DRG per diem is equal to reimbursement for applicable DRG divided by the average length of stay for that DRG.

I. New Facilities

1. Prospective payment rates for facilities with finally-settled base year cost reports which do not reflect 12 full months of operation or were not in operation during the base year will be determined as follows:

   a. For hospitals under the Hybrid system, payment will be at the statewide average for the appropriate DRG plus a percentage add-on for projected capital and medical education costs plus outlier payments as applicable.

   b. For freestanding long-term care psychiatric facilities, payment will be at the statewide average per diem for long term care psychiatric facilities plus projected capital and medical education costs as applicable.

   c. For Residential Treatment Facilities, payments will be based on a statewide average of all the RTF rates.

2. A new facility will submit its projected capital and medical education cost to the DHHS on the forms and in the format prescribed by the DHHS.

3. The rate for a new facility will apply until recalculation of the base year.

4. A new facility will not qualify for disproportionate share payments until the appropriate hospital fiscal year information is available.

J. Out-of-State Facilities

Payments to out-of-state facilities will be paid according to one of the following methods.

1. Contracting facilities in border states that submitted completed South Carolina specific Medicaid cost reports for the base year and other required documentation will be paid in accordance with in-state facility procedures.

2. When a rate has been set for a provider during a PPS rate period and the provider decides not to contract with the South Carolina Medicaid Program (SCMP) at anytime during that period, the facility will receive the set rate (with inflation applied if applicable).

3. Any provider approved to contract with the SCMP for which a facility-specific rate has not been calculated, will receive the statewide average rate. Facility-specific add-ons for Direct Medical Education, Indirect Medical Education and Capital may be calculated with the submission of information requested by the DHHS. The facility must send a written request in order for the DHHS to consider facility specific add-ons.

K. New Medicaid Providers

Prospective payment rates for established facilities which did not submit a South Carolina hospital-specific Medicaid cost report for the base year because the facility did not participate in the South Carolina Medicaid program at that time, will be determined as stated in I 1 a, b and c of this section.

L. Small Hospital Access Payments

Effective October 1, 1999, small hospital access payment adjustments will be paid to eligible hospitals in 4 quarterly installments throughout the year. In order to be eligible for this payment a hospital must meet the criteria defined in Section II 32 of this plan. The payment amount is equal to 13.5% of each qualifying hospital's total 1997 Medicaid revenue and will be allocated between inpatient and outpatient services.

M. High Volume Adjuster Payments

Effective October 1, 1999, high volume Medicaid adjuster payments will be paid to eligible hospitals in 3 installments throughout the year. In order to be eligible for this payment a hospital must meet the criteria defined in Section II 13 of this plan.

Qualifying hospitals will be eligible to receive a payment from the high volume Medicaid adjuster fund. Aggregate high volume Medicaid adjuster payments are equal to the difference between the aggregate adjusted DSH upper payment limit and the state's DSH allotment. High volume adjuster payments will not exceed 100% of the high volume hospital's unreimbursed Medicaid inpatient cost.

N. Newborn Hearing Screening Payments

Effective October 1, 2000, qualifying hospitals (see Section I C 18) will be reimbursed for Medicaid newborn hearing screenings. Payment adjustments will be made to pay $26 for each inpatient newborn claim that includes the ICD-9 procedure code 95.41 (newborn hearing screening).

O. Depo-Provera and Norplant Payments

Effective for admissions on or after October 1, 2001, hospitals will be reimbursed for Norplant and Depo-Provera. Payment adjustments will be made to pay $371.00 for each inpatient delivery claim that includes the procedure code X0097 (Norplant) and $43.29 for each inpatient delivery claim that includes the procedure code J1055 (Depo-Provera).

P. Small Rural Public Hospital Cost Settlements

Effective for services provided on or after October 1, 2001, the hospitals listed in Section I C 1 c of this plan, will be eligible to receive inpatient and outpatient cost settlements. The settlement amount will be prospectively set using the most current available base year data trended forward. Cost will be trended using the CMS Hospital Market Basket Forecast Rates. Payments will reflect changes from the base year to the payment period. For FFY 2002, the base year cost report used was FY 1999.

VII. Disproportionate Share

A. Payments

Disproportionate share hospital (DSH) payments shall be made in accordance with the requirements of Section 1923 of the Social Security Act and the South Carolina state legislature. DSH payments will be paid to those facilities meeting the requirements specified in Section II 11.

1. Effective October 1, 2000, DSH payments will be set as follows:

   a. Public hospital DSH payments will be equal to each hospital's inflated upper payment limit adjusted by the new Medicaid revenue paid to hospitals. New Medicaid revenue includes rate increases, high volume adjuster payments, small hospital access payments, newborn hearing screening payments and cost settlements.

   b. Non-public hospital DSH payments will be equal to 90% of each hospital's inflated upper payment limit adjusted by the new Medicaid revenue paid to hospitals (as defined in a above).

   c. SC Department of Mental Health (SCDMH) hospital DSH payments will be equal to each hospital's inflated upper payment limit for SC uninsured patients.

2. Effective for services provided on or after October 1, 2001, each hospital's upper payment limit reflects their inflated fiscal year 1999 unreimbursed Medicaid and uninsured SC patient cost with the exception of SCDMH hospitals (see 1 c above). Additionally, the cost limit of DSH hospitals designated as Level I trauma centers will include the unreimbursed extraordinary costs for the following services related to Level I centers: emergency room physicians, intensivists, CRNAs, ambulance, hospital-based teaching clinics (i.e., the unfunded professional (resident) cost incurred by hospital-based teaching clinics that provide outpatient clinic services to indigent patients), outside funding of indigent care services (i.e., hospital payments to community clinics that provide services for indigent patients who would otherwise get these services in the hospital emergency room), and Medicaid administrative days (i.e., the unreimbursed cost for patients who remain in the hospital after an acute care stay while waiting for nursing home placement). Inflated fiscal year 1999 unreimbursed costs for these trauma services for SC Medicaid and SC uninsured patients will be included in the DSH upper payment limit.

3. The following HCFA Market Basket indices will be applied to the hospitals' fiscal year 1999 base year cost.

Calendar year (CY) 1999	2.4%
CY 2000	3.9%
CY 2001	3.3%
CY 2002	3.1%

Inflation will be applied using the midpoint-to-midpoint inflation method. Costs will be inflated through the federal fiscal year.

4. All disproportionate share payments will be made by adjustments during the applicable time period.

B. Additional Requirements

All qualifying hospitals must adhere to the following rules as set forth in the memorandum of agreement between all participating hospitals and the South Carolina Medicaid Program.

1. The Provider's board chairman and either chief executive officer or chief financial officer shall meet with the DHHS's staff to ensure understanding of the DSH program;

2. The Provider agrees to participate in a peer review system to perform reviews of data resulting in DSH eligibility. Peer review and certification by the peer review group to the DHHS that the data is reasonable may be a prerequisite to a hospital receiving a DSH payment based on the data. Any dispute about the validity of the data must be resolved between the affected hospital, the peer review group and the DHHS;

3. The DHHS will escrow funds and make DSH payments to those hospitals deemed eligible by DHHS. The State Auditor's Office (SAO) may be asked to perform a comparison of data based on agreed-upon procedures subsequent to payment;

4. The Provider agrees to be responsible for supplying acceptable documentation to substantiate the allowable unreimbursed costs in the event of a CMS audit. If the audit results in a payback, the Provider is responsible for the payback amount. This will apply to DSH payment disallowances for payments made on or after October 1, 1999;

5. All payments are prospective. Only recoupments resulting from negative adjustments to data will be allowed.

IX. Changes to the Prospective Payment Rates

A. Future Redetermination of Prospective Payment Rates

1. In future years, prospective payment rates for acute care facilities will be established by trending forward the base year prospective payment rates by applying an inflation factor, as defined in Section IV, for the prospective payment year.

2. The outlier set-aside, as described in Section IV of this plan may be recalculated periodically.

3. The DHHS will recalculate the base year prospective payment rates as the agency deems necessary. Recalculation of the base year may involve recalibration of the relative weights, use of a more recent cost report base year or both.

4. The DHHS may recalculate the psychiatric residential treatment facility per diem rate each year based on a prior year's cost report data.

B. Rate Reconsideration

1. Providers will have the right to request a rate reconsideration if one of the following conditions has occurred since the base year:

a. Changes in case-mix since the base year. Such requests will be accompanied by documentation of the case-mix change using DRG case-mix index and severity of illness measures. Use of the DRG case-mix index alone is not satisfactory for rate reconsideration under this part. The severity of illness study may be based on a statistically valid random sample of Medicaid patients treated in the facility on an annual basis. If a sample is used, the sampling methodology including the standard error value will be included in the documentation.

b. An error in the facility's rate calculation. Such request will include a clear explanation of the error and documentation of the desired correction.

c. Extraordinary circumstances, such as acts of God, occurring since the base year and as defined by the DHHS. Such requests will be submitted along with documentation that clearly explains the circumstance, demonstration that the circumstance was extraordinary and unique to that facility, and the expenses associated with the circumstance.

2. Rate reconsideration will not be available for the following:

a. The payment methodology, case-mix adjustment, relative weights, inflation indices, DRG classification system.

b. Inflation of cost since the base year.

c. Increases in salary, wages, and fringe benefits.

3. Requests for rate reconsideration will be filed in accordance with procedures described in the Rate Reconsideration Manual that can be obtained upon request, from the Division of Acute Care Reimbursement. Rate reconsideration requests will be submitted in writing to the DHHS and will set forth the reasons for the requests. Each request will be accompanied by sufficient documentation to enable the DHHS to act upon the request. Rate reconsiderations for errors in the facility's rate will be submitted in writing within 30 days of the rate notification.

4. The request will be forwarded for review to the Division of Acute Care Reimbursement. This Division will review all requests for rate reconsideration and will issue a decision in writing to the provider.

5. The provider will be notified of the DHHS's decision within 90 days of receipt of the completed requested.

6. Pending the DHHS's decision on a request for rate reconsideration, the facility will be paid the prospective payment rate currently in effect, as determined by the DHHS. If the reconsideration request is granted, the resulting new prospective payment rate will be effective the later date of:

   a. The receipt of the request and supporting documentation requested by panel; or

   b. The first date of the prospective rate year, should the rate reconsideration be granted before this date; or

   c. The date on which the asset leading to the expenditure was placed into service.

7. In no case will a rate reconsideration revision be granted if it will result in a facility's reimbursement exceeding what would have been paid under Medicare principles of reimbursement.

8. Rate reconsiderations granted under this section will be effective for the remainder of the prospective rate year. Requests and documentation will be kept in a facility file and may be automatically reviewed in the following year if the panel has determined that the condition will continue to exist. The facility will be asked in future years to supply only necessary updated information.

9. Psychiatric residential treatment facilities may request a rate reconsideration within 30 days of receiving their rates. The rate reconsideration may be filed for the following circumstances:

   a. An error in the facility's rate calculation.

b. Amended costs and statistics submitted within 30 days of the receipt of notification of rates.

C. Appeals

1. A provider may appeal the DHHS's decision on the rate reconsideration. The appeal should be filed in accordance with the procedural requirements of the South Carolina Administrative Procedures Act (SCAPA) and the DHHS's regulations.

2. A provider may appeal the Capital and/or Direct Medical Education Final Settlement. The appeal shall be filed in accordance with the procedural requirements of the SCAPA and the DHHS's regulations.

X. Review and Reporting Requirements

A. Utilization Review Specific to Prospective Payment

1. Utilization Review will be conducted by the state or its designee. Utilization review conducted by the designee will be performed as outlined in the current contract.

2. Negative review findings are subject to payment adjustment. Hospitals that develop or show trends in negative review findings will be subject to educational intervention.

B. Cost Report Requirements

Cost report requirements under the hospital prospective payment system will conform to Medicare cost reporting principles and use as their basis the Medicare Cost Report Form - HCFA-2552. In addition, inpatient providers must comply with Medicaid specific cost report requirements as published by the DHHS.

1. Acute Care Hospitals

a. All acute care hospitals contracting with the SC Medicaid program must submit the HCFA-2552 cost report form within one hundred and fifty (150) days of the last day of their cost reporting period (or by the Medicare due date when an extension is granted by the Medicare program). Only hospitals with low utilization (less than 10 inpatient claims) will be exempt from this requirement.

b. Cost report data may be used for future rate setting, cost analysis, disproportionate share purposes and inpatient capital cost settlements. Effective October 1, 1999, SC Department of Mental Health hospital cost reports will be used for annual retrospective cost settlements.

c. Medicaid inpatient capital cost will be retrospectively settled. Capital cost will be settled at 100% of total allowable Medicaid inpatient capital cost for service dates on or after October 1, 2000. In accordance with OBRA 1993 requirements, disproportionate share hospitals will not be eligible for cost settlements since they will receive payment for 100% of their unreimbursed SC Medicaid cost through the SC DSH program.

d. Administrative days and associated cost, charges and payments will be reported on a supplemental worksheet issued by the DHHS. These days, cost, charges and payments must remain separate from all other Medicaid reported data. There will be no settlement for administrative days

2. Psychiatric Residential Treatment Facilities

All psychiatric residential treatment facilities will submit the HCFA-2552 form as well as a certified audited financial statement. The HCFA-2552 will be completed using each facility's fiscal year statistical and financial information. Each facility will be required to submit these documents within one hundred and fifty (150) days of the last day of their cost reporting period.

C. Audit Requirements

All cost report financial and statistical information as well as the medical information contained on claims, is subject to audit by the DHHS or its designee. The audited information may be used for future rate calculations, inpatient capital and direct medical education cost settlements, disproportionate share program requirements, utilization review contractor requirements and other analyses.

1. Cost reports of non-disproportionate share hospitals will be desk-audited in order to calculate capital cost settlements. Capital cost will be settled at 100% of total allowable Medicaid inpatient capital cost for service dates on or after October 1, 2000, and may be processed within 2 years after the end of a hospital's cost report period. Capital cost will be settled at 85% for service dates prior to October 1, 2000.

2. Supplemental worksheets submitted by hospitals qualifying for disproportionate share payments will be reviewed for accuracy. No additional payments will be made as a result of these reviews. Adjustments will be made only when reviews uncover overpayments or result in loss of disproportionate share status.

3. Medical audits will focus on the validity of diagnosis and procedure coding for reconciliation of appropriate expenditures made by the DHHS as described in A of this section.

4. Retrospective cost settlements will apply to RTFs as follows:

   a. There will be no retrospective cost settlement for psychiatric RTFs when audited base year cost data is used to set the reimbursement rate.

   b. There will be a retrospective cost adjustment for psychiatric RTFs when an interim rate is set on unaudited base year cost data. If the interim rate includes subsequent period add-ons, a retrospective cost adjustment will be performed on this subsequent period cost. Only recoupments resulting from negative adjustments will be allowed.

   c. There will be a retrospective cost settlement for state owned and operated psychiatric RTFs. These will be settled at 100% of allowable cost.

   d. There will be no retrospective cost adjustment for RTFs that are paid the statewide average rate.

2. Effective October 1, 1999, the Outpatient Fee Schedule rates increased. The new rates can be found in the Hospital Manual. In addition, a portion of the small hospital access payment (see 4.19-A Section VI) will be allocated to outpatient services.

3. Effective for services provided on or after October 1, 2001, the hospitals listed in ATTACHMENT 4.19-A, section I C 1 c of the plan, will be eligible to receive inpatient and outpatient cost settlements. The settlement amount will be prospectively set using the most current available base year data trended forward. Cost will be trended using the CMS Hospital Market Basket Rates. Payments will reflect changes from the base year to the payment period. For FFY 2002, the base year cost report used was FY 1999.

4. Effective for services provided on or after October 1, 2001, public disproportionate share (DSH) qualifying hospitals will be eligible to receive outpatient payment adjustments from a designated pool of funds. The pool will be proportionately allocated based on each DSH qualifying public hospital's unreimbursed outpatient cost. This payment will not exceed 100% of the Medicaid outpatient Upper Payment Limit based upon the FY cost report used to establish DSH payments.

B. Objectives

Implementation of the reimbursement methodology provided herein has the following objectives:

- To contain growth in the rate paid for outpatient services.
- To encourage outpatient resources be used when they are appropriate substitute for inpatient hospital services.
- To discourage the inappropriateness of outpatient hospital resources as a substitute for physician office and clinic services.
- To ensure the continued existence and stability of the core providers who serve the Medicaid population.